Interim Provider Payments During the Transition to New GAMMIS

During the transition from the existing Georgia MHN system to the new Georgia MMIS, some providers may experience slight delays in payment of claims as the Department of Community Health (DCH), HP Enterprise Systems, and providers transition to the new system. Not all providers may experience payment delays during the transition. This method of requesting interim provider payments is temporary for the transitional period only.

Effective November 1, 2010, to facilitate continuity of business during the transition, providers who experience delays in their payments due to billing problems, higher than normal denied or suspended claims may request an interim provider payment by submitting an Interim Provider Payment Request Form. The form will be available on the Georgia web site at www.mmis.georgia.gov or by contacting the HP Contact Center @ 1-800-766-4456.

Providers are required to submit the information required on the form for an interim provider payment to be considered. Providers will be required to attest to the billed amount of submitted claims and the conditions of the interim provider payment. Payment will be based on the lesser amount of:

- 80 percent of the billed sum of claims submitted but not paid
- 80 percent of the historical claims average payment totals for the payee
- The amount of the requested Interim Provider Payment

The Department of Community Health reserves the right to impose a different interim payment limitation if is deemed necessary

The forms are to be submitted on a retrospective basis, meaning that prior to completing the form; the provider must wait for the issuance of their Remittance Advice to determine the outcome of their weekly claims submission.

The provider is responsible for assuring that the Interim Provider Payment Request Form is signed before it is submitted. The provider may submit the Interim Provider Payment Request Form via fax or email. The form must be received by noon on Thursday to be considered for the week's payment cycle. Only one form per week, per payee, will be accepted. Forms received after the processing deadline will be considered for the following week's payment cycle.

A new form must be completed and submitted for each interim provider payment requested. The interim provider payment will be issued to the Payee by the same payment method currently on record with DCH. Under no circumstances will payments be available for pick-up. Providers should plan accordingly to allow time for processing of the request and issuing of the payment.

The interim provider payment will be automatically recouped when the provider's claims are later processed through the automated claims processing system and must be fully repaid in accordance with Medicaid Policy Manual, Part 1, related to Overpayment Recovery.

Georgia Medicaid Management Information System
GAMMIS
Interim Provider Payment Request Form

All fields marked with an asterisk (*) are required. The form will not be processed without this information.

TRANSACTION TYPE

Section 1

☐ Interim Payment Request ☐ Cancel / Discontinue Interim Payment (Only Section 2 and 4 are required for cancellation)

PAYEE IDENTIFICATION

Section 2

1. Federal Tax Identification Number (TIN) *	2. Medicaid Payee Provider Number *		
3. Name of Payee *			
4. Street Address	5. City	6. State	7. Zip
8. Total Percent of Annual Revenue from Medicaid/PeachCare for Kids Programs * _____%			
9. List the names and dates of persons who attended Provider Training *			

CLAIM / PAYMENT INFORMATION

Section 3

1. Type of Media for the Claim Submission *

☐ Paper ☐ Web Portal ☐ PES Software ☐ 837 Health Care Claim Electronic Transaction

2. Enter the one week period (Saturday thru Friday) that the below claim information pertains to (example 11/06/2010 thru 11/12/2010) *

From: To:

3. Number of Claims (if known) Not Processed thru the GAMMIS or Denied in Error for the Week

4. Billed Amount of Claims Not Processed thru the GAMMIS or Denied in Error for the Week *

5. Total Payment received (if any) for the Week *

6. Total Interim Payment Amount Requested for the Week *

7. Description of Billing or Processing Issues Causing Payment Delay *

8, Rendering Providers for which interim payment is requested (optional). This information can be used by the Payee to allocate the payment received, but will NOT be used by DCH to allocate specific recovery amounts.

Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount

Georgia Medicaid Management Information System
GAMMIS
Interim Provider Payment Request Form (continued)

CONTACT INFORMATION FOR THE PERSON PREPARING THE FORM

Section 4

1. Contact Name *	2. Printed Name *
3. Business Email Address *	4. Business Phone Number *

FAX OR EMAIL FORM TO:

Section 5

1. Fax Number:	2. Email Address:
(866) 421-0142	Interimpmts@dch.ga.gov

ATTESTATION

Section 6

PAYEE attests that the charges listed above have been submitted and not paid, that each service has been billed only once, and that the information is truthful and accurate.

PAYEE attests to, and understands that, the interim payment will be automatically recouped when the provider's claims are later processed through the automated claims processing system and even if the interim payment is not automatically recouped, the payee must fully repay the interim payment in accordance with Medicaid Policy Manual, Part 1, related to Overpayment Recovery.

1. Authorized Signature *	2. Printed Name *	
3. Title of Authorized Person *	4. Business Phone Number ^	5. Date *

-- FOR DCH USE ONLY --

Section 7

1. Request Processed by		2. Date Processed
3. Payment Approved ☐ YES ☐ NO	4. If Approved, Payment Amount	5. Payment Method ☐ OCP ☐ RP
	4. If Denied, Reason	